6144 Route 25A
Building C, Suite 13
Wading River, NY 11792
Ph: 631-886-2844
Fax: 631-886-2842

Island Rheumatology and Osteoporosis, PC

46 Little East Neck Road
Suite 2
Babylon, NY 11702
Ph: 631-539-0588
Islandrheumatology.com

NEW PATIENT INFORMATION FORM

Patient Name: _____ **Date of Birth/Age**: _____

Home Address: _____

_____**Best Phone Number**_____

Primary Care Doctor (phone/fax#): _____

Referring Doctor (phone/fax#): _____

Reason for your visit today: _____

INSURANCE INFORMATION			
Primary Insurance Holder's Name			D.O.B.
Relationship			
Employer			Phone
Address			Supervisor
City/Zip			Notes
Primary Insurance Company			Insured's ID #
Contact			Policy #
Phone			Group #
Notes			Claim #
Primary Insurance Company			Insured's ID #
Contact			Policy #
Phone			Group #
Notes			Claim #
Additional Information			

Height_____ Weight_____

Do you Smoke tobacco? **Yes** **No**

Have you ever smoked tobacco? **Yes** **No**

Do you drink any alcohol? **Yes** **No**

How often do you drink alcohol? **Rarely Socially Daily**

Preferred Pharmacy Name/Location: _____

_____

Occupation: _____

Thank you for allowing us to participate in your health care and welcome to our Rheumatology Practice
Please visit us at www.islandrheumatology.com

Past Medical History :(please circle)

Acid Reflux
Anemia – Low blood count
Arthritis
Asthma
Cancer or Malignancy
Colitis
COPD (Emphysema/Bronchitis)
Diabetes
Fibromyalgia
Gout
Headaches/Migraines
Heart Disease (Stents or Heart Failure)
Hepatitis B or C
High Blood Pressure
HIV/AIDS
Kidney Disease
Leukemia/Lymphoma
Liver Disease
Lupus or SLE
Osteoporosis/Osteopenia
Psoriasis
Rheumatoid Arthritis
Stomach Ulcers
Stroke/ TIA
Thyroid disorder

OTHER MEDICAL CONDITIONS: _____

Allergies to Medications or Latex: _____

Current Medications: Please bring a medication list with dose and frequency taken.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Surgical History: Please any surgeries you may have had and the approximate Month and Year

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Family Medical History: Please list any major family medical problems *especially any* autoimmune or rheumatology history

Mother: _____

Father: _____

Siblings: _____

Extended Family: _____

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